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Quality Care for Kids – Vision & Hearing

EMINENCE INDEPENDENT

EMINENCE MIDDLE/HIGH

☐ **Male** ☐ **Female** **Age:** _______ **Grade:** _______ **Teacher:** ___________________

Print Clearly

NAME:____ **Date of Birth:**_______/______/_______

FIRST MI LAST

VISION SYMPTOMS AND HISTORY

Yes	No	?		Yes	No	?	
☐	☐	☐	Wears Glasses	☐	☐	☐	Blurred Vision
☐	☐	☐	Vision Loss	☐	☐	☐	Double Vision
☐	☐	☐	Eye Injury	☐	☐	☐	Gritty Sensation
☐	☐	☐	Head Injury	☐	☐	☐	Sensitive to Light
☐	☐	☐	Red Eyes	☐	☐	☐	Sits close to TV
☐	☐	☐	Dry Eyes	☐	☐	☐	Holds items close
☐	☐	☐	Watering Eyes	☐	☐	☐	Can't see the chalk board
☐	☐	☐	Blinks more than frequently	☐	☐	☐	Avoids close work
☐	☐	☐	Burning Eyes	☐	☐	☐	Sudden Vision Loss
☐	☐	☐	Encrusted Eyes or Lids	☐	☐	☐	Writes letters backwards
☐	☐	☐	Itching Eyes	☐	☐	☐	Leaves out words when reading
☐	☐	☐	Headaches	☐	☐	☐	Sees Spots
☐	☐	☐	Squints	☐	☐	☐	Sees Halos around light
☐	☐	☐	Eye Pain or Soreness	☐	☐	☐	Sees flashes of light
☐	☐	☐	Seasonal Allergies	☐	☐	☐	Loses place while reading
☐	☐	☐	Loss of Depth Perception	☐	☐	☐	Born Premature
☐	☐	☐	Loss of Color Vision	☐	☐	☐	Had Vision Therapy
☐	☐	☐	Bumps into objects with one side of the body	☐	☐	☐	Other ______________

Did we see your child LAST YEAR at school?
☐Yes ☐No

If yes, were the results normal ?
☐Yes ☐No

Date of last Eye Exam : __________________
Was an Rx written ☐Yes ☐No
Did "we" write it? ☐Yes ☐No

Eye Dr.: ________________________________

<u>**Allergic**</u> to any medications? ☐Yes ☐No
If so, what?
____

<u>On a Prescribed</u> Medication now:
☐Yes ☐No If so, what and what for?

Check Child or Family for the following:

Child / Family		Child / Family	
____/____	Lazy Eye	____/____	Blindness
____/____	Crossed Eye	____/____	Eye Disease
____/____	Glaucoma	____/____	Macular Degeneration
____/____	Diabetes	____/____	Retinitis Pigmentosa
____/____	Cataracts	____/____	Stroke

1. Have Glasses now ? ☐Yes ☐No
2. Wear them regularly ? ☐Yes ☐No
3. Are they Lost ? ☐Yes ☐No
4. Are they Broken ? ☐Yes ☐No
5. Need another pair ? ☐Yes ☐No

Student Address: ____

City: ___________________________ **Zip** ________________

Phone:____

Social Security No. : _________________________________

Height____________Weight___________

PLEASE READ…
Those with Insurance will receive a FULL exam.
Those without Insurance will receive a Screening.
Those that do not pass the Screening are provided a full exam.
Your insurance WILL be billed. You <u>will NOT</u> be billed for the balance.

<u>**CIRCLE INSURANCE BELOW**</u>

PASSPORT AETNA BETTER HEALTH WELLCARE HUMANA ANTHEM

____
Medicaid ID Managed Care ID

OR Commercial Insurance: BCBS United Health Care, Aetna, Tricare Bluegrass Family Health, Cigna, Humana, Anthem

____
Guarantor Name Guarantor DOB

Guarantor ID: _________________ Social:___________________

Do you have vision coverage? ☐Yes ☐No

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☐ **Male** ☐ **Female** **Age:** _______ **Grade:** _______ **Teacher:** ____________________

NAME:____ **Date of Birth:**_______/______/_______

FIRST MI LAST

HEARING SYMPTOMS AND HISTORY

Yes	No	?	
☐	☐	☐	Ask to have things repeated
☐	☐	☐	Plays music too loud
☐	☐	☐	Plays TV too loud
☐	☐	☐	Not pay attention when called
☐	☐	☐	Watches speakers lips
☐	☐	☐	Has a lot of ear wax
☐	☐	☐	Has many ear infections
☐	☐	☐	Has Tubes in ears now
☐	☐	☐	Had tubes but not now
☐	☐	☐	Diagnosed with hearing loss
☐	☐	☐	Failed a hearing test
☐	☐	☐	Wears a hearing aid
☐	☐	☐	Missing an ear
☐	☐	☐	Earaches
☐	☐	☐	Has had a head trauma
☐	☐	☐	Has had ear surgery
☐	☐	☐	Lots of ear drainage
☐	☐	☐	Experience dizziness

Yes	No	?	
☐	☐	☐	Muffled speech
☐	☐	☐	Difficulty understanding words
☐	☐	☐	Ask others to speak more loudly
☐	☐	☐	Ask others to speak more clearly
☐	☐	☐	Withdraws from conversations
☐	☐	☐	Has middle ear abnormality
☐	☐	☐	Complains about loud noises
☐	☐	☐	Has cochlear implants
☐	☐	☐	Has ruptured eardrum
☐	☐	☐	Around loud noise all the time
☐	☐	☐	Shoots guns often
☐	☐	☐	Has hereditary hearing problems
☐	☐	☐	Has speech therapy
☐	☐	☐	Born premature
☐	☐	☐	Does not respond to loud noise
☐	☐	☐	Ringing in the ears
☐	☐	☐	Uses Q-Tips
☐	☐	☐	Wear headphones a lot

If you answered **YES** to any item or have another issue not listed, please explain in detail:

____

Date of last Hearing Exam : ____________

Diagnosed with hearing loss ☐Yes ☐No

Dr.: _____________________________

Did we see your child last year at school for Hearing ? ☐Yes ☐No

If yes, were the results normal ? ☐Yes ☐No

Check Child or Family for the following:

Child / Family		**Child / Family**	
____/____	Deaf	____/____	Down syndrome
____/____	Hearing aids	____/____	Autistic
____/____	Diabetes	____/____	Otosclerosis
____/____	Seizures	____/____	Meningitis

➡ **PLEASE READ…**

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VISION & HEARING Notes and concerns from Parent, Teacher, FRC or School Nurse:

I request and authorize Quality Care for Kids "QCFK" to perform a routine vision and hearing test on my child. I authorize my Commercial, Medicaid or other Insurance Benefits, be paid directly to QCFK. I authorize QCFK to provide a summary of findings to my child's school, physician or specialist if a problem is identified. I authorize QCFK to dilate my child's eye if necessary.

☐ **I DO NOT** give permission to dilate my child's eyes

Race

____ American Indian
____ Alaska Native
____ Native Hawaiian
____ Asian
____ White
____ Black / African American

Ethnicity

____ Hispanic or Latino
____ Not Hispanic or Latino

☒ ________________________________ Parent or Guardian Signature

☒ ______________________________ Printed Name of Parent or Guardian

☒ ______________ Date

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